CNA, who was observed treating residents with exceptional kindliness and care, *said, "I have a real sense of why we're here. I never realized it until I worked at a factory, packing boxes. The money is better, but ... I couldn't stand it... it's meaningless. Here, every day is totally different.* " Another CNA said, *"I got burned out a while back, and worked at a factory. I can't imagine doing that for a living. It was completely meaningless."*

5.6.5 Dementia Care: Adjusting to Residents With Dementia and Caring for Them

"I loved the people over there, they were sweet, the type of patients. They were very loving. They would hug you one minute but hit you the next. But that was the disease, not them. I like these patients. One of them said to me today, 'you're back,' after I was off for three days. That makes you feel good." – CNA

'How do you handle problems with dementia patients?', the researcher asked. *"I don't take it personal. A lot of times they don't know what they are doing. But, even with dementia, they know if they are being abused. They might act stubborn all day. Somebody else can be mean to them, and it will reflect on you,"* said one CNA

Is the dementia unit harder to staff? *"Actually that's not as much of a challenge. The staff likes the family feeling of 20 people on a neighborhood. There is a core group who work there every day, including housekeeping and a CNA. Dietary takes the food down there and CNAs serve it. They have had some classes and special training on dementia. They try to help the staff understand how dementia can affect a person, by putting cotton in their ears, or deadening their senses, or messing up their glasses, and trying to get them to understand what it is like. It helps a lot. They have a lot of intervention skills. There are no staffing needs there. A lot of times people request to work there, a few because it is lighter care, less physical lifting, but it is still more work for your brain. Most of the people can still walk."*- Administrator, low turnover facility.

Dementia care as observed in this study clearly took both specific training and a special kind of person. One LPN explained in detail just what it was like to take care of mid-stage dementia residents. *"You have to have the right mind to take care of these people. None of these patients know my name when I go around and do rounds, no matter how long I've been taking care of them! I've been spit at, kicked at, you have food thrown at you, every day when you come to work."* Then she gave some examples of creative ways in which she had reduced residents' distress, while maintaining their safety (see box below). It seemed to the researcher that if aides had been permitted or encouraged to train with this nurse, perhaps their difficult experiences in dealing with dementia might have been translated into good ones, giving them more confidence and success in this difficult job.

Stories of Sensitive Dementia Care: Possible Teaching Material for Nursing Staff

Let me tell you a story. There was a resident named Diana. She was a big smoker. All she wanted was cigarettes, cigarettes, cigarettes. Of course this is a non-smoking facility. She was driving us crazy, all the time wanting cigarettes, never stopping... So, Nancy (the DON) said, We have to get her on drugs. I said, Nancy, we're going to fix her without drugs. I'm going to let her smoke. Nancy said, "What do you mean?" and I said, "Watch this." And I cut a straw, and stuffed the end with cotton, and colored part of it pink with a magic marker. Then I got a tongue depressor to simulate a match, and I gave her this 'cigarette.' And I said, Diana, here's your cigarette.' And I (making motions) "lit" that tongue depressor against my thigh, and I said, now, would you like coffee with your cigarette? Let me give you an ashtray." And, she was puffing away on this straw, saying to everyone else, "Oh, these are really good." She was walking up and down the hall, telling everyone. One time she had four of these 'cigarettes' hanging out of her mouth. And I kept after her, "Diana, don't burn a hole in the carpet." I guess I'm half nuts! But she was calm and quiet, without a single drug!

Then there's my bus stop. Everybody here wants to go home. So, I made a bus stop." (Sure enough, there is a large sign saying "bus stop" right near a few comfortable chairs by the nurse's station.) *"And, so I tell them, the bus stop is down here. Go ahead and wait for the bus. And, while you're waiting, don't you want a snack? Something to drink? And before you know it, they have forgotten they are waiting for the bus, and eventually they go on and do other things. But sometimes I have had half the floor down here, waiting for the bus. I guess it's something about my tone of voice. I am really sincere about it.* (She almost had the researcher convinced there is a bus stop there.)

And we use props. We have a big bag of fake money. Some of them are worried about money—they need rent money, they are afraid of being thrown out of their apartment. So we give them rent money, and collect it, and give them a receipt, and they are on cloud nine.

Licensed Practical Nurse – on a Dementia Unit

This nurse was gifted in her ability to calm and soothe dementia patients without hurting them. She was describing her own specific way to implement 'validation therapy,' a currently favored technique to work with dementia patients that is in stark contrast to the 'reality therapy' that many nurses learned in school, if they learned anything. She could have done a tremendous job helping other people learn to take care of these residents as well.

The researcher asked whether she could share these techniques with the other staff. "*We had an Alzheimer support group. It was a 7-week and then a 10-week course. It was an*

incredible course. I try to tell my staff... they are uneducated, they have no training. Sometimes they think that the residents are acting this way on purpose. They can't realize that they can't help it. Every now and then I hear someone say, 'she did that on purpose,' and I have to remind him or her that's not true. The better non-professional staff eventually gets it. You got to be real patient. It takes a certain personality. You have to not be bothered when you are sworn at, or when you come up to them to hug them, and they hit you, or throw their milk at you. Some aides can't stand it. You have to realize it's something else that's upsetting them, it's not personal." Does she have any role in hiring non-professional or professional staff to work with her on this unit? *"No, not really,"* she said.

5.6.6 Involvement in Care Planning

Recent research has confirmed that facilities where CNAs participate in care planning have lower rates of turnover compared to similar facilities where they do not. (Cite) Yet in virtually no facility, high or low turnover, were CNAs actively involved in care planning. At most, sometimes nurses asked them for input before the meetings. In some cases, even the charge nurses were not involved in care planning meetings.

"*No, but... we'd like to, it's just too hard.*" – Director of Nursing, high turnover

"*Well, the facility wasn't doing that. I usually have a CNA on the safety committee, the one who is most recently injured. I've been trying to do that. I want to get the CNAs and RMAs involved in the care plans. I'm trying to get a true CQI [continuous quality improvement] up and running. We already do the weight variance, that kind of thing. As a S____employee, these were things we had to do. That's my background. Of course, here we have no space. But when we get the employee lounge I'm going to put a CQI chart up in there.*"
Administrator, high turnover

5.6.7 Communication and Report

As mentioned in the section on leadership, communication between employees, especially across hierarchical boundaries and between shifts, was found in this study to be very important. Some more motivational workplaces have instituted the ritual of 'report' from one shift to the next, even at the level of the CNA instead of just the nurse. "*At the frontline level, everyone has multiple things to do. The acuity level has increased dramatically and everyone is busy, so the charge nurses say, 'I don't have time to supervise.' They need to know it is not optional. They need to be in touch with the staff, with what goes on. Recently they have succeeded somewhat in having the nurses give CNAs report. They need to empower them, as professionals, not just to change beds. They do not feel valued. The job is very difficult.*"

5.6.8 Teamwork—or its Absence

Remarkably few of the facilities studied for this report used teams of nursing assistants, or even nursing teams. One facility did, on the first shift, and aides said they liked working there because they had a partner to help them, to work with, and to talk with. But other managers said, "*They don't work together too well. There are personality conflicts. I want them to solve it themselves.*" However, leaving it to the aides to solve 'themselves' was not working.

Of course establishing teams requires both management training and sufficient staff, both of which are in short supply in the nursing facility industry. One CNA noted, " If there are more staff, it is not as tiring. We have a lot of total care. I mostly leave (places) because of the pay. I don't like being the new person on the block. I don't like to move from job to job. You want to leave if there is no teamwork. On this shift it is stable. There have been the same nurses and aides for a year."

5.6.9 What it Used to be Like: Acuity, Staff, Regulation, etc.

A pervasive sense permeated all the facilities visited that 'things have changed' even in the last five years, such as increased paperwork, increased patient acuity, more cost and time pressure, and the workforce. "*Five years ago, there were a large number of people with 15 years' service. They were people who took a little extra time with the PMs (evening rounds), would sing, put on a variety show, work on a float together....* – An RN, former DON in a low turnover facility. Another nursing director in a low-turnover facility said, "*We used to have time to have fun with each other... laughed with the residents, and soaked their feet, spent 30 or 45 minutes with them, gave them a truly good pedicure, so that even someone with difficult nails... There is nothing better than having your feet soaked, and the residents loved it! Now we farm it out to a podiatrist, if we do it at all.*"

Resident acuity is seen as much higher. "*You don't have any more nice little old ladies. When I got here the census was in the low 80s, and I overheard the social service person saying to a hospital discharge planner, 'don't you have any nice little old ladies?' I had to stop that. So now we are up to 90. Yes. I will take the little old ladies, if they are private pay. But we get lots of inquiries for paraplegics, HIV. We never had an HIV patient until I got here. I had to have a massive in-service.*" – Administrator in a high turnover facility

5.6.10 Attachment, Sadness, Death, Distance

One administrator told a story about how she got very close to and attached to an Italian lady in her job during college. One day she came in and the lady's room was empty, cleaned out.

"Usually when they just go to the hospital they don't clean it out like that. I asked, 'What happened to so-and-so?' 'Oh. she died last night.' And then I cried, right there in the middle of the floor. I realized then that I couldn't get attached. You have to keep a distance." Yet facility managers or social workers could work on helping people deal with the inevitable approach of death for at least some of their residents. Attending to death carefully and explicitly is a practice (as noted above in the section on leadership) that is drawing increasing attention, both for staff and residents, in the 'culture change' community in long-term care.

5.6.11 Summary

In summary, the problem with the work organization and care practices observed in most of the facilities was that they didn't seem to be allowing the caring for people as they wished to be cared for, even if they could so communicate. And where they could not communicate, the assignment system of rotation diminishes the likelihood of making a positive match between nurse's aides and residents.

5.7 Sufficient Staffing Ratios and Support for High Quality Care

"More people would stay CNAs if there was more CNAs, so we wouldn't have 13 residents or ten residents. It's hard to keep residents dry, feed them, and on top of that give showers. There's just not enough time." --21-year-old female Hmong CNA, 3 months' experience, in college and working full time, at a high turnover facility

"More staffing would make them stay. Working short makes them leave." - CNA

The fifth and final management practice that clearly was associated directly with turnover and retention rates in the facilities visited for this chapter relates to nurse aide staffing in particular, and nurse staffing in general. While there was no 'magic' ratio that emerged in this study, it was clear that virtually no aide felt she could adequately take care of more than eight present-day nursing facility residents on day shifts, about the same number on evening shifts, and somewhere between 10 and 15 on night shifts, depending on how active and alert residents were at nighttime. Licensed nurses felt strongly that having full responsibility for even 20 residents at a time on their shifts was unsafe, but it was alarmingly common.

5.7.1 Understaffing and Working "Short"

One Filipino nurse said, *"Sometimes there is understaffing so I cannot give really proper caring. There is one nurse to 20 residents. We cannot handle them as we would like. We just give them the pills. It is just functional, but not communicating. It's not how it is supposed to be."* Administrators in high-turnover homes tended to complain about current staffing ratios, whatever their level in their state (Kansas requires 2.0 hours of nursing time a day, California requires 2.9). One administrator said, "We staff at 2.7 or thereabouts but of

course some days we will slip down to 1.9 or so, and if you ask me can you do that forever, no, but can you do it once in a while? Sure. And I don't think the government should regulate staffing, that will just cause more problems, no one is ever going to be fully staffed all the time." Another said that when people called in, *"We have nothing to cover them, it's a big problem. The regulations here in Ca. have changed. Now that we can't count the licensed nurses' hours double, it's hard to maintain 3.2 nursing hours. I have some of the CNAs working 8 hours instead of 7.5, but not too many."* One Registered Nurse at a high-turnover facility said that she had her scheduled staffing only 20 percent of the time, and even the scheduled staffing was too low in her opinion.

An aide said directly, *"Working short causes people to leave—it makes them feel as if the work they do doesn't matter."* Sometimes aides are driven to threaten direct action when things get bad enough. This only happened in high-turnover homes in this study. *"We only have two [aides] tonight, we are supposed to have three. When this happened for two nights in a row, we told the management, we are going home if somebody else doesn't come in, on the third night. And you can feel it when you have more people. I get home, my legs hurt, my back hurts. Sometimes it goes smooth sometimes, and sometimes, it doesn't. If one person is sick, has the runs, or falls, and you are doing vitals every two hours! We hate it."*

Most administrators and nursing directors readily acknowledged the direct connection between insufficient staffing and high turnover. *"We have a high turnover rate, mostly of CNAs. Some of it is dissatisfaction with the physical demands, the psychological demands, the emotional demands, it can be difficult. Also it's the ratio of CNAs to resident-- there are too many residents per CNA. We have better than some other places, 1 CNA to 10 residents is pretty good.... But there is a lack of time to meet emotional needs. The career CNAs talk about the times when they could do the patients' hair and fingernails, or sit and talk with them and look at pictures. There was a high level of reward from that."*

The Filipino RNs seemed to have the most problems with staffing, at least on second shift where many were concentrated. What do you need to do a good job? *"More nurses. There is only one nurse here for the three to eleven pm shift. There are 40 residents! And they are all trying to leave. And they all need feeding and medications, and charting and the CNAs need supervision. We need more staff per patient, first and foremost. Second, the administration."* What about it? *"More communication, more listening, not a one-way process."*

When asked why CNAs leave, one RN was quite direct. *"They are overworked. They need more staffing."* What would be the right level of staffing? *"In the hospital, if it is critical care, it was one to one. And in this place in the Philippines it would usually be 1 to 8."* One DON in a high turnover facility said, *"On good days I run CNAs at a 1:10 ratio, evenings 1:15, and nights 1:20."* But there were a lot of "not good" days. Another administrator said, *"Good providers will do the right thing. We staff much higher than the minimum staffing*

ratios in Kansas." Yet even providers with relatively high staffing levels were having trouble staffing at a level they felt was adequate.

Some administrators saw that they needed more direct care staff relative to management. *"We have to create a social environment. I'd like to get rid of middle management and get more caregivers. The more restrictions we get, the more specialists we have. If we have more CNAs, we will have better happiness and better staff will be there."*

Staffing at the right level in this study was not just a matter of more bodies. For instance, agency staff were sometimes felt to be more trouble then they were worth since they had to be trained and supervised and usually, they did not know the residents, did not know where their dentures are, whether they wore glasses, how they needed to be fed, dressed, and toileted. Yet agency staff were paid almost twice as much for every hour on the job as regular staff, and often brought with them a negative attitude about anyone who would do this kind of work for less than they did, according to both managers and CNAs.

5.7.2 Building on Intrinsic Motivation

Good care could be its own reward, generating both feedback from residents and families and feelings of worth—but this seemed to be rare. In part that was because there was so little time for the activities that generated such positive feedback. *"When people speak who haven't spoken for months, or when I see a light in their eyes that hasn't been there for ages, it makes it all worthwhile,"* said one charge nurse, the one who wore bunny ears on Easter. This was in stark contrast to a high-turnover facility where residents were treated much more roughly: "*What do YOU want*" was a typical comment overheard by the researcher. Also, the series of responses below was typical of CNA interviews in all three states.

What do you like about the job? "I enjoy helping people, helping the residents, giving them support, keeping their spirits up, making them happy."

What don't you like about the job? "The lack of CNAs. There are NOT enough CNAs. We have to work short. Then you have TOO MANY residents to yourself, and not enough help. If we have 13 residents to one person, and we have to shower 2 or three, and get five down, it's just two much. That's the main problem."

How many residents do you have? "It varies. It goes from 10 to, like tonight, we have 20 each." *(Someone called in, which seemed like a routine occurrence.)*

5.7.3 Corporate Policies

When asked about agency staff, most facility managers said they did not use it very much. One said, "No, *that costs too much; corporate won't let us.*" While corporate policies were

not studied in this report, they clearly had an effect on the human resources and staffing practices described herein, and would be a useful subject for a future study.

Staff shortages were also real in several areas, though they were exacerbated by low wages and poor working conditions. Some managers felt torn between hiring more people and hiring good people. *"It's better not to get the wrong people in. We've got a good group up here right now. I am left with a good crew now. There is a shortage everywhere. We need more nurses and more CNAs. Maybe more money would help. If we had more staff, it would be easier on the people.... Even if you were making a lot of money, and you were working yourself to death... They're trying, but I guess they can't find anyone."*

As one CNA left her interview, she said, *"We've been praying for more staffing, every day."*

5.7.4 Summary

In conclusion, it seemed in these interviews that short staffing was a circular problem that could lead to more short staffing, in a kind of vicious cycle. When people worked short, they described getting more tired as well as more resentful, and then they said they were more likely to call in in the future, making it more likely that someone else would work short. Also, more injuries were reported by workers on short-staffed units, and they also said that residents were more difficult to comfort and soothe, since time was scarcer. The ability to develop relationships that would bring the injured person back to work, feeling an obligation to the resident, was less likely to be present in a short-staffed setting, or one where everyone was rotated constantly.

Perhaps the last word on staffing could be left to a young, 21 year old Hmong CNA who was finishing her second month in her job, and going to school full time. 'How was your first two month time here?' asked the researcher. *"Well, it was good but it gets hectic sometimes, confusing, hard, because of the shortage of CNAs. We have up to 13 people at one time, to feed them all, sometimes it's frustrating. When I was hired here they were short. Two of us were hired at the same time. Four work each night for 40 residents, is what they told us. Orientation and training was four days, with a CNA, I watched her do rounds, where things are, then got my own patient load. Class prepares me very well but the difference is in the time, so you have to do them simpler. For example. when I am changing them, I want to use not just one pad, but another for safety, it's really hard. You are supposed to do one patient at a time, but I'll do one and go to the next one and come back, to fit it all. There is less time, and more people, and you have to do everything faster and quicker."*

5.8 Conclusion

This chapter used field research to infer from 159 interviews and more than 100 hours of observation that five key managerial practices seemed to characterize the environments with lower turnover and better retention of nursing staff. These managerial practices were in some cases associated with individualized care practices with residents that are only possible with a stable and well-trained, well managed staff, although the focus of this report has not been the quality of care. While each facility has its own unique characteristics, and the ethnographic research on which this particular report is based is by definition limited in scope, the investigator believes that further research into these practices would yield larger-scale and more definitive evidence. The value of ethnographic research is in understanding the mechanisms for processes of interest, and it was the goal of this chapter to contribute to this larger effort.

The five key practices identified here included high quality leadership and management, a practice of valuing and respecting nursing staff, especially direct caregivers, positive human resource practices, both economic and non-economic, a set of work organization and care practices that help to retain staff and build relationships, and finally, a sufficient staffing ratio to allow for the provision of high quality care. Additional surprising findings included that even in a complex system, one person could make a vast difference--- particularly in a key leadership role in the facility, but also as charge nurse on a unit, or an HR or staff development person, as long as the individual had direct contact with the care giving decisions and staff members.

It is hoped this report provides a clear picture of high turnover homes compared to low turnover homes in the same labor markets, and makes the case that managerial practices can and do appear to contribute to reduced turnover. While these practices require both further large-scale, randomized evaluation and additional ethnographic study and careful implementation, they are not inaccessible or mysterious, and are clearly within the ability of most managers interviewed for this study. However, they also require significant discipline, a good deal of compassion and empathy, openness to learning and innovation, a willingness to delegate responsibility and to hold managers as well as staff accountable, and an interest in spending significant time on the floors or units of a nursing facility. Management practices do make a difference, according to the nursing staff interviewed for this study.

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Appendix A

Outline
Typical Process for Interviews at Selected Nursing Facilities in CA, WI, and KS.

1. Administrators
    a. I scheduled a 15 to 20 minute meeting with administrators, as the first level of contact in the facility, and also to introduce me to other managers and staff.
    b. For administrators, I focused on questions about mission and values, overall management philosophy, overall care philosophy, and perceptions of issues and problems related to recruitment, retention and turnover.

2. Directors of Nursing
    a. This interview lasted about 30 minutes, at least. I asked the DON about training, about supervisor and management relationships, about work assignments and scheduling, about her own background and experience and philosophy. Then I added turnover and retention questions, including about specific management practices of work organization and care organization, probing for resident-centered or worker-centered practices.
    b. I would also ask her to whom else I should talk and through her gain access for charge nurse and worker interviews in the targeted facilities.

3. Charge nurses
    a. I asked charge nurses all the questions about work and care organization, about quality, and some of the questions about training.
    b. I ordinarily sampled charge nurses for about two units per facility, depending on the size and composition of the facility, perhaps one 'ordinary' unit and one dementia unit, for instance.
    c. I spoke with both RN and LPN charge nurses
    d. I also asked about their backgrounds, recruitment, training in gerontology, their perceptions of issues of retention for their own classifications as well as those of CNAs' recruitment and retention.

4. CNAs –paraprofessional nursing employees
    a. I initially selected a sample of 4 or 5 CNAs in each case study facility, often to correspond with the units in which I interviewed charge nurses. I also interviewed at least 2 CNAs on evening and 2 on night shifts.

b. I wanted both senior and newly arrived employees as well as some medium term employees, depending on the profile of the facility.
c. I attempted to do formal or informal focus groups in the break room or at the beginning or end or middle of shift, though that depended on facility practices and voluntary support.
d. The paraprofessionals' perception of management practices, work and care organization, their intention to turn over, recruitment and attraction and selection, was important
e. I wanted to know about orientation and training, and relationships with managers, charge nurses, residents, and families. What keeps them there? What would make them leave? What is their past and desired future work experience?
f. I imagined a 15 to 30 minute interview with these workers, hopefully on their break time in a private place such as an unused office or a break room that has some privacy. Interviews lasted from 10 minutes to more than 1 hour, and occurred everywhere from lobbies to storage closets, on nursing stations, or in corners of dining rooms or quiet rooms.
g. I also considered small informal focus groups with varying other workers, to increase the breadth of the responding group.

5. Other people that I did interview in nursing homes re: recruitment, retention during this study

a. Staff development director
b. Human resource director and/or assistant
c. Scheduler
d. Whoever recruits, interviews, selects, and hires nursing staff
e. Quality assurance personnel
f. CEO or other officers who are on site
g. Residents who are willing and able to talk
h. Family members or family council members
i. Secretarial or administrative staff, especially if long term
j. Social services director
k. Activity director
l. Alzheimers' coordinators or directors
m. Assistant directors of nursing
n. Assistant administrators
o. Chaplain
p. Volunteers, especially regular ones